Exhibit 21

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

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JACKSONVILLE, IL 62651 OFFICIAL USE

Postage	$3.35	$2.75
Certified Fee		$0.00
Return Receipt Fee (Endorsement Required)		$0.00
Restricted Delivery Fee (Endorsement Required)	$0.70	$0.00
Total Postage & Fees	$6.80	$

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03/17/2017

Sent To: Jackson National Life Insurance Company
Street, Apt. No.; or PO Box No.: Attn.: Claim Services
PO Box 577
City, State, ZIP: Jacksonville, IL 62651-0577

PS Form 3800, August 2006 — See Reverse for Instructions

7013 3020 0000 5740 9069

EXHIBIT J-13B

000065

JAMES S. JANTOS
Attorney At Law
P.O. Box 258, Mercer Island, WA 98040
Telephone: (206) 232-0639 • Facsimile: (206) 232-0993
Email: jantos@speakeasy.net

Via U.S. Certified Mail #70133020000057409069

March 17, 2017

Jackson National Life Insurance Company
Attn.: Claim Services
PO Box 577
Jacksonville, IL 62651-0577

Telephone: (800) 366-3495

Re: Claim for Death Benefit
Group Universal Life Program for the Employees of Lockheed Martin
Group Policy Number: Z13041
Insured/Deceased: Kelly D. Couch

Dear Claim Services:

Please be advised that I represent Sterling Crum with respect to the above-referenced claim for death benefit. Please accept the following documentation enclosed herein:

1) Certificate of Death/ State of Georgia for Kelly Douglas Couch (1 page); and,
2) Completed Life Claimant Statement (5 pages).

Please accept this letter as instruction to direct all future correspondence regarding the above-referenced claim to me. Please call or respond if you have any questions.

Cordially yours,

James S. Jantos
Attorney at Law

LIFE CLAIMANT STATEMENT

Jackson National Life Insurance Company

Mailing Address
P.O. Box 577
Jacksonville, IL 62651-0577

Proof of Loss

Part I

INSTRUCTIONS

The following items are required for all claims:

- O An original **certified death certificate** showing the cause of death. Photocopies are not acceptable.
- O The original policy or, if unavailable, an explanation provided in Decedent Information section of this form.
- O **This claim form completed and signed by the claimant(s).**

If the policy has been in force for less than two years during the lifetime of the Insured or if the policy has been reinstated within two years of the Insured's death, then we may perform a routine inquiry into the answers on the application for the policy or reinstatement application of the lapsed policy.

If the death occurred outside of the United States, we will require a Report of the Death of an American Citizen Abroad.

Special Instructions and additional requirements may apply.

- **If the beneficiary is the Estate of the Insured,** we will also require evidence of the court approved legal representative over the Estate. Please provide the Tax ID number of the Estate of the Insured.
- **If the beneficiary is a trust,** we will also require a copy of the trust agreement and any amendments, including the signature page(s). Please note the Trustee Certification section of the claim form will also need to be completed by all trustees. Please use the trust's name when completing the Claimant Information section of the claim form and provide the Tax ID number of the trust.
- **If the beneficiary is a minor,** we may require evidence of court appointed guardianship of the Minor's Estate.
- **If the policy is collaterally assigned,** we will require a letter from the collateral assignee stating the balance due under the collateral assignment. If the collateral assignee is a corporation, please include a copy of the corporate resolution verifying who is authorized to sign on behalf of the corporation.
- **If the primary beneficiary(ies) is (are) deceased,** we will require a death certificate for each deceased beneficiary.
- **If the policy has a split dollar agreement associated with it,** we will require a copy of said agreement.
- **If the policy is subject to a Viatical or a Life Settlement transaction,** and if the beneficiary is a viatical settlement provider, life settlement provider, the receiver or conservator of viatical or life settlement company, a viatical or life financing entity, trustee, agent, securities intermediary or other representative of a viatical or life settlement provider or an individual or entity which invested in this policy as a viatical or life settlement, please complete the relevant questions.

Other requirements may be needed depending on the individual facts of the claim. The company will advise you if other documentation is required.

LIFE CLAIMANT STATEMENT

FRAUD INFORMATION

For Residents of Alaska, Arizona, Nebraska, New Hampshire and Oregon: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

For Residents of California: For your protection California law requires the following notice to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For Residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

For Residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For Residents of Kentucky, Ohio and Pennsylvania: Any person who knowingly & with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime & subjects such person to criminal and civil penalties.

For Residents of Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

For Residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

For Residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

For Residents of New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

For Residents of New York: Please see the Signature section of this form.

For Residents of Puerto Rico: Any person who, knowingly and with intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

For Residents of All Other States: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

LIFE CLAIMANT STATEMENT

DECEDENT INFORMATION

1. Name of Deceased (Last, First, Middle)	2. Last 4 digits of Deceased's Social Security No:
Couch, Kelly, Douglas	7981

3. If the Deceased was known by any other names, such as maiden name, hyphenated name, nickname, derivative form of first and/or middle name or an alias, please provide them below.
Couch, Douglas, Kelly

4. Policy Number(s)	5. If policy is lost or not available, please explain:
Z13041	Policy lost or missing

6. Deceased's Date of Death	7. Cause of Death	8.
6/10/2005	See Death Certificate	☒ Natural ☐ Accidental ☐ Suicide ☐ Homicide ☐ Pending

CLAIMANT INFORMATION

9. Claimant Name (Last, First, Middle). If trust, please list trust name and complete Trustee Certification section.
Crum, Sterling

10. Street Address	11. City	12. State and Zip	13. Daytime Phone Number
[redacted]			

14. Date of Birth	15. Social Security or Tax ID Number	16. Relationship to Deceased
[redacted]	[redacted]	Benefactor

17. I am filing this claim as:
☒ an individual who is named as a beneficiary under the policy
☐ a Trustee of a Trust which is named as a beneficiary under the policy
☐ an Executor of Estate which is named as a beneficiary under the policy
☐ Other

18. Are you a U.S. Citizen? ☒ Yes ☐ No
If "No" please list country of citizenship

19. **Policies subject to Viatical / Life Settlement transactions** - Are you a viatical settlement provider, life settlement provider, the receiver or conservator of viatical or life settlement company, a viatical or life financing entity, trustee, agent, securities intermediary or other representative of a viatical or life settlement provider; or an individual or entity which invested in this policy as a viatical or life settlement? ☐ Yes ☐ No

CLAIMANT INFORMATION (to be completed by 2nd claimant, if any)

20. Claimant Name (Last, First, Middle). If trust, please list trust name and complete Trustee Certification section.

21. Physical Address (No P.O. Boxes)	22. City	23. State and Zip	24. Daytime Phone Number

25. Date of Birth	26. Social Security or Tax ID Number	27. Relationship to Deceased

28. I am filing this claim as:
☐ an individual who is named as a beneficiary under the policy
☐ a Trustee of a Trust which is named as a beneficiary under the policy
☐ an Executor of Estate which is named as a beneficiary under the policy
☐ Other

29. Are you a U.S. Citizen? ☐ Yes ☐ No
If "No" please list country of citizenship

30. **Policies subject to Viatical / Life Settlement transactions** - Are you a viatical settlement provider, life settlement provider, the receiver or conservator of viatical or life settlement company, a viatical or life financing entity, trustee, agent, securities intermediary or other representative of a viatical or life settlement provider; or an individual or entity which invested in this policy as a viatical or life settlement? ☐ Yes ☐ No

YOUR SIGNATURE IS REQUIRED ON THE NEXT PAGE.

LIFE CLAIMANT STATEMENT

SETTLEMENT OPTIONS

The policy may contain one or more settlement options, such as Interest Payments, Installments for a Specified Amount, Life Annuity, Life Annuity with Period Certain, and/or Joint Life and Survivorship Annuity. You may choose to receive a lump sum payment or another settlement option available in the policy under which a claim is made. For more information, refer to the optional methods of policy settlement provision in the policy or contact us at the mailing address noted on the front of the claim form.

If you wish to select a settlement option**, please indicate your settlement selection by name (not by number) on the line below after you have carefully reviewed the options available in the policy. Availability of settlement options are subject to the terms of the policy. If you do not choose a settlement option, we will send a lump sum settlement to you.

Proof of age required: copy of birth certificate, driver's license or federal ID card. Proof is also required for Joint Payees. Benefits commence upon receipt of all requirements in good order.

_____
Name of Settlement Option from Policy

Important Information About the USA PATRIOT Act

To help fight the funding of terrorism and money-laundering activities, the U.S. government has passed the USA PATRIOT Act, which requires banks, including our processing agent bank, to obtain, verify and record information that identifies persons who engage in certain transactions with or through a bank. This means that we will need to verify the name, residential or street address (no P.O. Boxes), date of birth and social security number or other tax identification number of all account owners.

SUBSTITUTE FOR IRS FORM W-9

This information is being collected on this form versus IRS form W-9 and will be used for supplying information to the Internal Revenue Service (IRS). Under penalty of perjury, I certify that 1) the tax ID number above is correct (or I am waiting for a number to be issued to me), 2) I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, 3) I am a U.S. person (including a U.S. resident alien), and 4) I am exempt from Foreign Account Tax Compliance Act (FATCA) reporting. ***Please cross through item 2 if you have been notified by the IRS that you are subject to backup withholding because you have failed to report all interest and dividends on your tax return. Cross though item 3 if you are not a U.S. person (including a U.S. resident alien) and complete and return to us the applicable IRS Form W-8BEN or Form W-8BEN-E.***

For contracts issued in and residents of Illinois only:

A valid claim will include interest due and payable from the date of death at a rate of 10% if we do not pay the claim within 31 days from the latest of 1) the date that we receive proof of death, 2) the date we receive sufficient information to determine our liability and the appropriate beneficiary(ies) entitled to the proceeds; or 3) the date that any legal impediments are resolved.

SIGNATURES

I/We do hereby make claim to said insurance, declare that the answers recorded above are complete and true, and agree that the furnishing of this and any supplemental forms do not constitute an admission by the Company that there was any insurance in force on the life in question, nor a waiver of its rights or defenses.

For Residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
For Residents of All Other States: See the Fraud Information section of this claim form.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Sterling Cann — 3/8/2017
Signature of Claimant and Title — Date

Signature of Second Claimant, if any, and Title — Date

LIFE CLAIMANT STATEMENT

TRUSTEE CERTIFICATION

TRUSTEE CERTIFICATION (to be completed only if trust is claiming proceeds)

COMPLETE THIS SECTION ONLY IF A TRUST IS CLAIMING BENEFITS.
Please include a copy of the trust agreement, including the signature page(s) and any amendments.

I/We, the undersigned trustee(s), represent and warrant that the copy of the trust agreement, which we will provide you pursuant to this certification, is a true and exact copy of said agreement, that said agreement is in full force and effect, and that we have the authority to make this certification.

Generation Skipping Transfer Tax Information - THIS MUST BE COMPLETED FOR PAYMENT

I/We the undersigned, on oath, deposes and states as follows with respect to the possible application of the Generation Skipping Transfer (GST) tax to the death benefit payment (Mark the appropriate item):

____1.The GST tax does not apply because the death benefit is not included in the decedent's estate for federal estate tax purposes.

____2.The GST tax does not apply because the GST tax exemption will offset the GST tax.

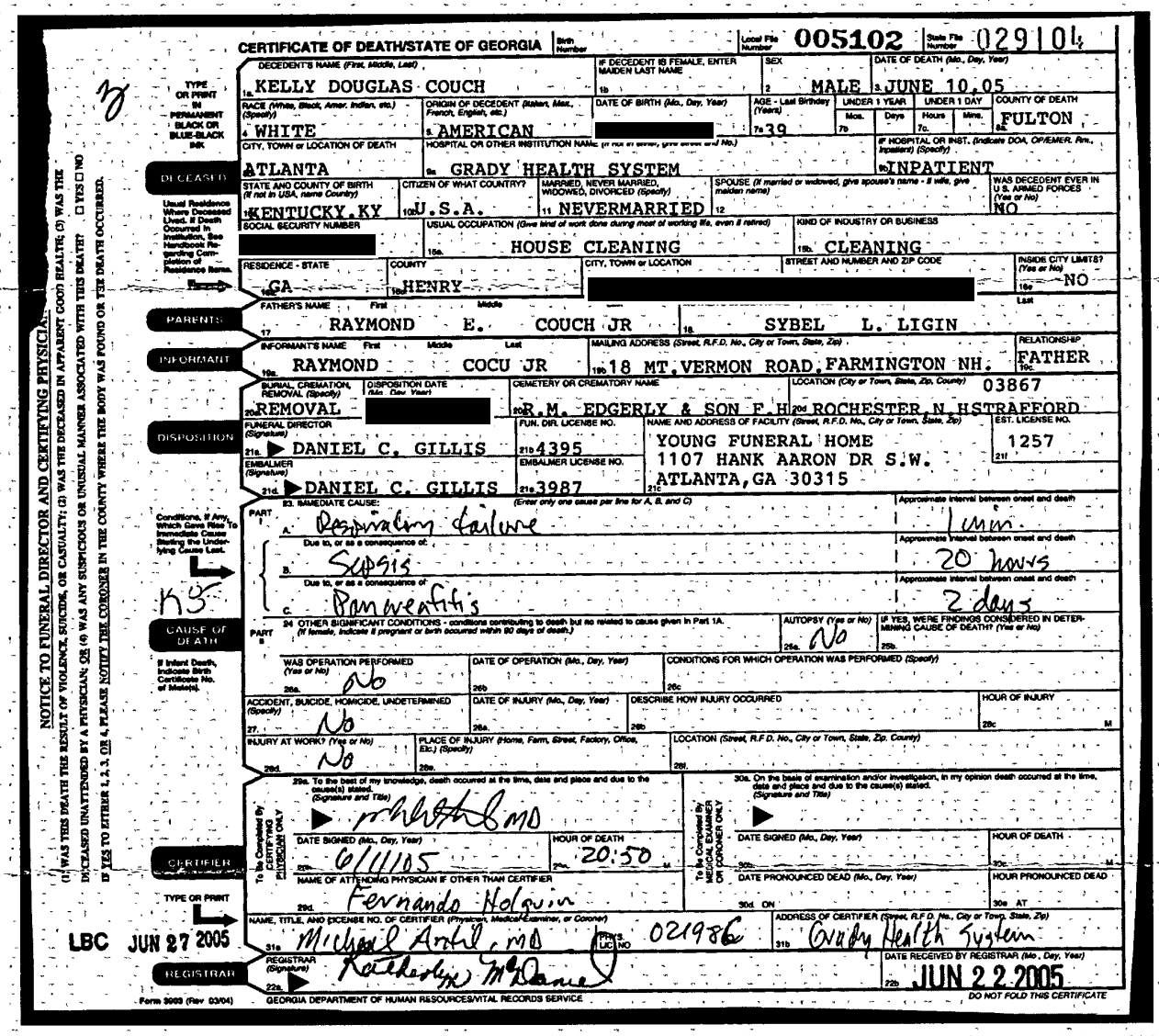
____3.The GST tax does not apply because at least one of the trust beneficiaries is not a "skipped" person.

____4.The GST tax does not apply because of the reasons set forth in the attached document (Please attach document setting forth the reasons why you believe the GST tax does not apply.)

____5.The GST tax may apply. As a result, the death benefit payment IS subject to withholding of the applicable GST tax. Enclosed is the completed Schedule R-1 (Form 706) for submission to the Internal Revenue Service.

Name of Trust	Date of Trust Agreement
Date of all Amendments	Trust Tax ID Number

Printed Name of Trustee(s)	Signature(s)
a_____	_____
b_____	_____
c_____	_____
d_____	_____



CERTIFICATE OF DEATH/STATE OF GEORGIA

Local File Number 005102 State File Number 029104

1a. DECEDENT'S NAME (First, Middle, Last): KELLY DOUGLAS COUCH
1b. IF DECEDENT IS FEMALE, ENTER MAIDEN LAST NAME:
2. SEX: MALE
3. DATE OF DEATH (Mo., Day, Year): JUNE 10,05
4. RACE (White, Black, Amer. Indian, etc.) (Specify): WHITE
5. ORIGIN OF DECEDENT (Italian, Mex., French, English, etc.): AMERICAN
6. DATE OF BIRTH (Mo., Day, Year): [redacted]
7a. AGE - Last Birthday (Years): 39
7b. UNDER 1 YEAR: Mos. / Days
7c. UNDER 1 DAY: Hours / Mins.
8. COUNTY OF DEATH: FULTON
9. CITY, TOWN or LOCATION OF DEATH: ATLANTA
9a. HOSPITAL OR OTHER INSTITUTION NAME: GRADY HEALTH SYSTEM
9b. IF HOSPITAL OR INST. (Indicate DOA, ER/EMER. Rm., Inpatient) (Specify): INPATIENT
10a. STATE AND COUNTY OF BIRTH (If not in USA, name Country): KENTUCKY, KY
10b. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): NEVERMARRIED
12. SPOUSE (If married or widowed, give spouse's name - if wife, give maiden name):
13. WAS DECEDENT EVER IN U.S. ARMED FORCES (Yes or No): NO
14. SOCIAL SECURITY NUMBER: [redacted]
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE CLEANING
15b. KIND OF INDUSTRY OR BUSINESS: CLEANING
16a. RESIDENCE - STATE: GA
16b. COUNTY: HENRY
16c. CITY, TOWN or LOCATION: [redacted]
16d. STREET AND NUMBER AND ZIP CODE: [redacted]
16e. INSIDE CITY LIMITS? (Yes or No): NO

PARENTS
17. FATHER'S NAME (First, Middle, Last): RAYMOND E. COUCH JR
18. MOTHER'S NAME (First, Middle, Last): SYBEL L. LIGIN

INFORMANT
19a. INFORMANT'S NAME (First, Middle, Last): RAYMOND COCU JR
19b. MAILING ADDRESS (Street, R.F.D. No., City or Town, State, Zip): 18 MT.VERMON ROAD,FARMINGTON NH.
19c. RELATIONSHIP: FATHER

DISPOSITION
20a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
20b. DISPOSITION DATE (Mo., Day, Year): [redacted]
20c. CEMETERY OR CREMATORY NAME: R.M. EDGERLY & SON F.H
20d. LOCATION (City or Town, State, Zip, County): ROCHESTER,N.H,STRAFFORD 03867
21a. FUNERAL DIRECTOR (Signature): DANIEL C. GILLIS
21b. FUN. DIR. LICENSE NO.: 4395
21c. NAME AND ADDRESS OF FACILITY (Street, R.F.D. No., City or Town, State, Zip): YOUNG FUNERAL HOME, 1107 HANK AARON DR S.W., ATLANTA,GA 30315
21d. EST. LICENSE NO.: 1257
21e. EMBALMER (Signature): DANIEL C. GILLIS
21f. EMBALMER LICENSE NO.: 3987

CAUSE OF DEATH
23. IMMEDIATE CAUSE: (Enter only one cause per line for A, B, and C)
PART I
A. Respiratory failure — Approximate interval between onset and death: 1 min.
Due to, or as a consequence of:
B. Sepsis — Approximate interval between onset and death: 20 hours
Due to, or as a consequence of:
C. Pancreatitis — Approximate interval between onset and death: 2 days
PART II
24. OTHER SIGNIFICANT CONDITIONS - conditions contributing to death but not related to cause given in Part 1A. (If female, indicate if pregnant or birth occurred within 90 days of death.)
25a. AUTOPSY (Yes or No): No
25b. IF YES, WERE FINDINGS CONSIDERED IN DETERMINING CAUSE OF DEATH? (Yes or No):
Conditions, if Any, Which Gave Rise To Immediate Cause Stating the Underlying Cause Last.
If Infant Death, Indicate Birth Certificate No. of Mother(s).
26a. WAS OPERATION PERFORMED (Yes or No): No
26b. DATE OF OPERATION (Mo., Day, Year):
26c. CONDITIONS FOR WHICH OPERATION WAS PERFORMED (Specify):
27. ACCIDENT, SUICIDE, HOMICIDE, UNDETERMINED (Specify): No
28a. DATE OF INJURY (Mo., Day, Year):
28b. DESCRIBE HOW INJURY OCCURRED:
28c. HOUR OF INJURY:
28d. INJURY AT WORK? (Yes or No): No
28e. PLACE OF INJURY (Home, Farm, Street, Factory, Office, Etc.) (Specify):
28f. LOCATION (Street, R.F.D. No., City or Town, State, Zip, County):

CERTIFIER
29a. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title): [signature] MD
To be Completed by CERTIFYING PHYSICIAN ONLY
29b. DATE SIGNED (Mo., Day, Year): 6/11/05
29c. HOUR OF DEATH: 20:50
29d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER: Fernando Holguin
30a. On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title):
To be Completed by MEDICAL EXAMINER OR CORONER ONLY
30b. DATE SIGNED (Mo., Day, Year):
30c. HOUR OF DEATH:
30d. DATE PRONOUNCED DEAD (Mo., Day, Year):
30e. HOUR PRONOUNCED DEAD:
31a. NAME, TITLE, AND LICENSE NO. OF CERTIFIER (Physician, Medical Examiner, or Coroner): Michael Arnold, MD
PHY'S LIC. NO: 021986
31b. ADDRESS OF CERTIFIER (Street, R.F.D. No., City or Town, State, Zip): Grady Health System

REGISTRAR
22a. REGISTRAR (Signature): [signature]
22b. DATE RECEIVED BY REGISTRAR (Mo., Day, Year): JUN 22 2005

NOTICE TO FUNERAL DIRECTOR AND CERTIFYING PHYSICIAN: (1) WAS THIS DEATH THE RESULT OF VIOLENCE, SUICIDE, OR CASUALTY; (2) WAS THE DECEASED IN APPARENT GOOD HEALTH; (3) WAS THE DECEASED UNATTENDED BY A PHYSICIAN; OR (4) WAS ANY SUSPICIOUS OR UNUSUAL MANNER ASSOCIATED WITH THIS DEATH? ☐ YES ☐ NO
IF YES TO EITHER 1, 2, 3, OR 4, PLEASE NOTIFY THE CORONER IN THE COUNTY WHERE THE BODY WAS FOUND OR THE DEATH OCCURRED.

TYPE OR PRINT IN PERMANENT BLACK OR BLUE-BLACK INK

LBC JUN 27 2005

Form 3903 (Rev 03/04) GEORGIA DEPARTMENT OF HUMAN RESOURCES/VITAL RECORDS SERVICE DO NOT FOLD THIS CERTIFICATE

THIS IS TO CERTIFY THAT THIS IS A TRUE AND CORRECT COPY OF THE CERTIFICATE FILED WITH THE STATE OFFICE OF VITAL RECORDS, GEORGIA DEPARTMENT OF PUBLIC HEALTH. THIS CERTIFIED COPY IS ISSUED UNDER THE AUTHORITY OF CHAPTER 31-10, CODE OF GEORGIA AND 511-1-1 DPH RULES AND REGULATIONS.

STATE REGISTRAR AND CUSTODIAN
GEORGIA STATE OFFICE OF VITAL RECORDS

DATE JAN 1 2 2017

(VOID WITHOUT IMPRESSED SEAL OR IF ALTERED OR COPIED)